

**HEALTH CARE FINANCING ADMINISTRATION
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-00001/9

TITLE: Hawaii Health QUEST Demonstration

AWARDEE: Hawaii Department of Human Services

1. The State shall define a minimum data set (which at least includes inpatient and physician services) and require all providers to submit these data. The State must perform periodic review, including validation studies, in order to ensure compliance. The State shall have provisions in its contract with health plans to provide the data and be authorized to impose financial penalties if accurate data are not submitted in a timely fashion. The State shall develop a work plan showing how collection of plan encounter data will be implemented and monitored; the work plan shall also identify State resources that will be assigned to this effort. The work plan shall describe how the State will use the encounter data to monitor implementation of the project and feed findings directly into program change on a timely basis. The work plan is due within 60 days of the date of approval. If the State fails to provide accurate and complete encounter data for any managed-care plan, it will be responsible for providing to the designated CMS evaluator data abstracted from medical records comparable to the data, which would be available from encounter reporting requirements.
2. The State shall provide quarterly expenditure reports (CMS-64s) that provide expenditures on those currently eligible, those who would have been eligible under State plan amendments in the absence of section 1115 waivers, and those eligible under section 1115 waivers. CMS will provide Federal Financial Participation only for annual expenditures that do not exceed pre-defined limits on the costs incurred, following the attached budget guidelines.
3. Prior to the start date of the demonstration, the State must submit evidence that health plan and physician capacity is adequate to serve the expected enrollment as part of the ongoing monitoring effort of the demonstration. This will include a discussion on how individuals, who currently rely on Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), will continue to have access to health care through the managed care delivery system, if FQHCs and RHCs choose not to provide such services under a managed care approach.
4. The State must fully meet the usual Medicaid disclosure requirements for contracting providers prior to the start date of the demonstration.
5. The State shall require health plans to contract with FQHCs. If a managed care organization can demonstrate to the U.S. Department of Health and Human Services and to the Hawaii Department of Human Services that both adequate capacity and an appropriate range of services for vulnerable populations exists to serve the expected enrollment in all service areas without contracting with FQHCs, the plan can be relieved of this requirement.

6. For those plans that do not meet section 1903(m) requirements, prior to award of contract to these plans, the State shall submit for CMS approval a description of their delivery system, their financial viability, and their quality assurance system.
7. The State will submit quarterly progress reports, which are due 60 days after the end of each quarter. The reports should include a discussion of events occurring during the quarter that affect health care delivery, quality of care, access, financial results, benefit package, and other operational issues. The report should include a separate discussion of State efforts related to the collection and verification of encounter data. The report should also include proposals for addressing any problems identified in the quarterly report. Utilization of health services based on encounter data should be reported on a quarterly and cumulative basis by health plan. At a minimum, this should include physician visits, hospital admissions and hospital days per 1,000 member months, broken out by AFDC adults and children, Section 1902 (r)(2) children (which include SHIP and QUEST-Net children), and General Assistance (GA) children.
8. The State will submit a draft annual report, documenting accomplishments, project status, quantitative and case study findings, and policy and administrative difficulties no later than 120 days after the end of the State fiscal year. Within 30 days of receipt of comments from CMS, a final annual report will be submitted.
9. During the last 6 months of the demonstration, no enrollment of individuals who would not be eligible under current law will be permitted.
10. Hawaii must implement procedures so that hospitals will be able to distinguish individuals who are eligible under current law (including those eligible under section 1902 (r) and related provisions) from individuals who are only eligible because of the demonstration. The proposed procedure must be submitted to CMS for approval within 60 days of the date of approval.
11. Hawaii will implement modifications to the demonstration by submitting revisions to the original proposal. The State shall not submit amendments to the approved State plan relating to the new eligibles.
12. The State's new eligibility rules under the demonstration will not adversely affect Medicaid eligibility of persons who:
 - (a) have been determined to be eligible for Medicaid under spend down criteria prior to the start date of the demonstration;
 - (b) have income above 100 percent FPL, and
 - (c) remain eligible as of the day immediately prior to the start date of the demonstration,but only to the extent that these persons continue to meet the Medicaid spend down eligibility criteria in effect on the day immediately prior to the start date of the demonstration.

13. The State must assure that an adequate Management Information System (MIS) is in place prior to enrollment of beneficiaries. At a minimum, the system must be able to track current enrollment by plan.
14. The State must develop internal and external audits to monitor the performance of the plans. At a minimum, the State shall monitor the financial performance and quality assurance activities of each plan. Within 45 days of award, the State must submit a work plan to the CMS project officer that includes detailed criteria for monitoring the financial stability and quality assurance controls of each plan. The State will submit to the Center for Medicaid and State Operations and to the San Francisco Regional Office copies of all financial audits of the participating health plans and quality assessment reviews of these plans.
15. The State must continue to assure that its eligibility process is accurate. Within 30 days of award. As part of this recent extension, the State will submit a description of the quality control procedures that it intends to use in the demonstration.
16. A draft final report should be submitted to the CMS project officer for comments. CMS's comments should be taken into consideration by the awardee for incorporation into the final report. The awardee should use the CMS's Author's Guidelines: Grants and Contracts Final Reports in the preparation of the final report. The final report is due no later than 90 days after the termination of the project.
17. The CMS project officer or designee will be available for technical consultation at the convenience of the awardee within 5 working days of telephone calls and within 10 working days on progress reports and other written documents submitted.
18. CMS may suspend or terminate any project in whole, or in part, at any time before the date of expiration, whenever it determines that the awardee has materially failed to comply with the terms of the project. CMS will promptly notify the awardee in writing of the determination and the reasons for the suspension or termination, together with the effective date.
19. The awardee shall assume responsibility for the accuracy and completeness of the information contained in all technical documents and reports submitted. The CMS project officer shall not direct the interpretation of the data used in preparing these documents and reports.
20. The awardee shall develop and submit detailed plans to protect the confidentiality of all project-related information that identifies individuals. The plan must specify that such information is confidential, that it may not be disclosed directly or indirectly except for purposes directly connected with the conduct of the project, and that informed written consent of the individual must be obtained for any disclosure.

The CMS project officer shall be notified prior to formal presentation of any report or statistical or analytical material based on information obtained through this project. Formal presentation includes papers, articles, professional publications, speeches, and testimony. In the course of this research, whenever the principal investigator determines that a significant new finding has been developed, he or she will immediately communicate it to the CMS project officer before

formal dissemination to the general public.

21. The final report of the project may not be released or published without permission from the CMS project officer within the first 4 months following the receipt of the report by the CMS project officer. The final report will contain a disclaimer that the opinions expressed are those of the awardee and do not necessarily reflect the opinions of CMS.
22. Certain key personnel, as designated by the CMS project officer, are considered to be essential to the work being performed on specific activities. Prior to altering the levels of effort of any of the key personnel among the various activities for this project, or to diverting those individuals to other projects outside of the scope of this award, the awardee shall notify the CMS project officer reasonably in advance and shall submit justification (including name and resume of proposed substitution) in sufficient detail to permit evaluation of the impact on the project. No alteration or diversion of the levels of effort of the designated key personnel from the specified activities for this project shall be made by the awardee without the approval of the CMS project officer.
23. At any phase of the project, including at the project's conclusion, the awardee, if so requested by the project officer, must submit to CMS analytic data file(s), with appropriate documentation, representing the data developed/used in end-product analyses generated under the award. The analytic file(s) may include primary data collected, acquired, or generated under the award and/or data furnished by CMS. The content, format, documentation, and schedule for production of the data file(s) will be agreed upon by the principal investigator and the CMS project officer. The negotiated format(s) could include both file(s) that would be limited to CMS internal use and file(s) that CMS could make available to the general public.
24. At any phase of the project, including at the project's conclusion, the awardee, if so requested by the project officer, must deliver to CMS any materials, systems, or other items developed, refined, or enhanced in the course of or under the award. The awardee agrees that CMS shall have royalty-free, nonexclusive and irrevocable rights to reproduce, publish, or otherwise use and authorize others to use the items for Federal Government purposes.
25. CMS reserves the right to withdraw waivers at any time if it determines that continuing the waivers would no longer be in the public interest. If a waiver is withdrawn, CMS will be liable for only normal closeout costs.
26. In order to track expenditures under this demonstration, Hawaii must submit the following forms for "Hawaii Health QUEST" on a quarterly basis. Submit only one set of CMS-64s for the project.

CMS-64.9	CMS-64.9a
CMS-64.9p	CMS-64.9o
CMS-64.10	CMS-64 Certification
CMS-64.10p	CMS-64 Summary

Report all administrative and service expenditures allowed under the waivers approved for this

demonstration. Do not include expenditures related to research and evaluation activities. These activities are funded separately.

27. The awardee shall, within a reasonable period of time to be defined by the Secretary, conform the demonstration to any national health care reforms that may be enacted.
28. Hawaii will be responsible for developing a detailed operational protocol describing the section 1115 demonstration. The protocol will serve as a stand-alone document that reflects the operating policies and administrative guidelines of the demonstration. The protocol will be submitted for approval no later than 180 days after the extension period begins. Hawaii shall assure and monitor compliance with the protocol.

**Monitoring Budget Neutrality for the
Hawaii Health QUEST Demonstration**

Individuals who are eligible under the demonstration will be one of three types: (1) those who are currently eligible under Hawaii's existing Medicaid State plan; (2) those who could be eligible for Medicaid under Section 1902(r) and related provisions if Hawaii amended its State plan; and (3) are those who could not be eligible without section 1115 waivers. Hawaii will be at risk for the per capita cost (as determined by the method described below) for current eligibles (as defined by groups 1 and 2 above) but not at risk for the number of current eligibles. By providing Federal Financial Participation (FFP) all current eligibles, Hawaii will not be at risk for changing economic conditions. However, by placing Hawaii at risk for the per capita costs for current eligibles, CMS assures that the demonstration expenditures do not exceed the level of expenditures had there been no demonstration.

There are two steps involved in the calculation of the annual budget limit: determining baseline estimates of the number of Medicaid eligibles and the cost per eligible; and determining the method for inflating these estimates over time. Administrative costs under the demonstration will be excluded from the budget neutrality formula.

The inflation factor will be based on an adjusted actual index: the Consumer Price Index for health care (CPI-H) for Honolulu. The actual inflation factor that will be applied to the per capita costs will be $CPI + 4$ percent.

The initial per capita cost estimate will be based on the 1993 per capita costs of current eligibles, inflated to the beginning of the demonstration. The per capita costs will be calculated for AFDC adults and children; Section 1902 (r)(2) children (which include SHIP and QUEST-Net children who could be eligible for Medicaid under an expansion of the State Plan based on Section 1902(r) authority), and General Assistance (GA) children. The 1993 monthly costs for these groups were \$188.72 for AFDC adults and children; \$109.37 for Section 1902 (r)(2) children (excluding disproportionate share), and the per capita for the General Assistance (GA) children is the same as the 1902 (r) children.

The annual limit on Medicaid expenditures will be the product of the inflated per capita cost estimate for that year times the number of Medicaid eligibles (limited to those who would have been eligible without the demonstration, including expansions that could have been authorized under State plan amendments). In other words, the annual limit will be the sum over the above three eligibility groups of the product of the inflated per capita cost times the number of eligible months that year for that group.

Budget neutrality will be determined over an eleven-year basis instead of the current eight-year basis. The annual expenditure limits will be determined retroactively once the annual CPI has been determined through year 11.

Any savings from budget neutrality may only be applied to an eligibility expansion or to offset

demonstration costs in excess of the annual budget limits during this period. The State must submit for CMS approval a waiver amendment requesting the expansion. In its amendment, the State must demonstrate that the expansion is sustainable, even when the accrued savings from the initial eight-year waiver period are exhausted.

MONITORING SYSTEM

The State shall provide quarterly expenditure reports using the form CMS-64 to separately report expenditures for those receiving services under the Medicaid program and those participating in QUEST under section 1115 authority. These groups are identified in the following manner:

1. AFDC - Medicaid related adults and children
2. Section 1902 (r)(2) children (which include the SHIP, QUEST-Net, & General Assistance children)
3. Those who could be not otherwise be eligible for Medicaid without an 1115 waiver.

To track expenditures under this demonstration, Hawaii must submit a complete CMS-64 form according to standard Medicaid reporting requirements through the MBES that clearly differentiates between program expenditures made under the authority in CMS's approval of the QUEST demonstration and expenditures which are made under ordinary Medicaid rules not affected by the waiver, on a quarterly basis according to standard Medicaid reporting requirements. In addition, quarterly supplemental schedules that reconcile to the reported CMS-64 QUEST amounts must be concurrently submitted that detail QUEST services.

In addition to the CMS-64, the State shall provide to CMS on an annual basis (related to the period for which the expenditure limit is established) the actual caseloads for each of the QUEST programs, and by appropriate groups within each of the programs. This caseload information should be provided to CMS 180 days after the end of the year.

For a period of two years after the termination of the waiver, the State must continue to separately identify net expenditures related to dates of service during the operation of the 1115 waiver on the modified form CMS-64 in order to properly account for these expenditures in determining budget neutrality.

The State shall ensure that all costs claimed for Federal financial participation under the demonstration are not already being reimbursed through existing statewide or department cost allocation plans. Such costs as overhead and administration for new programs and state staff may not duplicate costs already being charged to the Medicaid Program.